STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

Whole Health Medical Center, PC
Petitioner

Case No. 11-802-BC
Docket No. 11-000794-OFIR

v

Blue Cross Blue Shield of Michigan,
Respondent

Issued and entered
this 3rd day of August 2012
by Randall S. Gregg
Deputy Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan of one of its participating providers, Whole Health Medical Center, PC. Based on its audit findings, BCBSM concluded it had overpaid the provider $152,724.24 during the audit period March 1, 2001 through August 13, 2003.

The provider disputed BCBSM's audit findings. A Review and Determination proceeding was held by the Commissioner's designee[1] who concluded that BCBSM had violated section 402(1)(f) of the Nonprofit Health Care Corporation Reform Act of 1980 ("Act 350"), MCL 550.1402(1)(f). The Commissioner's designee also concluded that BCBSM was entitled to recover $102,178.20.

The decision was appealed to the Commissioner by Whole Health Medical Center. A contested case hearing was scheduled for June 6, 2012. The Petitioner failed to appear at the hearing. The administrative law judge, in a Proposal for Decision (PFD) issued June 8, 2012, entered a default ruling against the Petitioner. Neither party filed exceptions to the PFD.

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1. See section 404 of the Nonprofit Health Care Corporation Reform Act of 1980, MCL 550.1404.

II. Findings of Fact

The factual findings in the PFD are in accordance with the record and are adopted.

III. Conclusions of Law

The Commissioner adopts the conclusion, stated in the PFD, that the Petition for a Contested Case should be dismissed, the Petitioner having failed to appear at hearing to offer proof of the allegations stated in the Petition.

The PFD recommends that the findings in the Review and Determination be adopted. The Commissioner adopts the findings and recommendations in the Review and Determination with one exception. The Commissioner does not adopt the conclusion that BCBSM failed "to make a good faith attempt at a prompt, fair and equitable settlement on denied claims" for five BCBSM members whose records were part of the BCBSM audit. There is no evidence that BCBSM's actions demonstrated bad faith. In fact, the claims were not denied, but were actually paid. BCBSM acted to recover the amounts its audit concluded were overpayments. It is not appropriate to conclude that BCBSM violated section 402(1)(f) of Act 350.

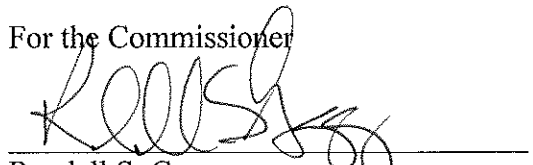
All other findings in the Review and Determination, including the amount of overpayment, are adopted.

IV. Order

It is ordered that BCBSM may seek recovery of $102,178.20 from the Petitioner.

R. Kevin Clinton
Commissioner

For the Commissioner



Randall S. Gregg
Deputy Commissioner

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:	Docket No. 11-000794-OFIR
Whole Health Medical Center, P.C., Petitioner	Agency No. 11-802-BC
v	Agency: Office of Financial & Insurance Regulation
Blue Cross Blue Shield of Michigan, Respondent	Case Type: OFIR/OFIS-Insurance
/	Filing Type: Appeal

Issued and entered
this 8th day of June 2012
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

This proceeding commenced with the filing of a Notice of Hearing dated May 11, 2011, scheduling hearing for June 8, 2011. The Notice of Hearing was issued pursuant to a Request for Hearing received by the Michigan Administrative Hearing System on May 10, 2011, and an Order Referring Complaint for Hearing and Order to Respond, with Complaint dated May 10, 2011, issued by the Special Deputy Commissioner Randall S. Gregg of the Office of Financial and Insurance Regulation under the provisions of the Nonprofit Health Care Corporation Act, 1980 PA 350, as amended, MCL 550.1101 *et seq.* (hereafter "Nonprofit Act"). The parties appear to have exhausted their rights to administrative review under 1986 AACS, R 550.101-108.

The Notice of Hearing was sent by certified mail to the parties at their last known addresses, and informed the parties that if they failed to appear at the scheduled hearing a default might be entered, pursuant to Sections 72 and 78 of the Michigan Administrative Procedures Act, 1969 PA 306, as amended, MCL 24.101, *et seq.* (hereafter "APA").

On June 2, 2011, the undersigned issued an Order Granting Adjournment, rescheduling the hearing date to July 19, 2011. On July 14, 2011, the undersigned issued an Order Granting Adjournment and Scheduling Telephone Prehearing Conference. On July 19, 2011, a telephone prehearing conference was held. Alan T. Rogalski, Attorney at Law,

appeared at the prehearing conference on behalf of Whole Health Medical Center, P.C., Petitioner; and Bryant D. Greene, Attorney at Law, appeared at the prehearing conference on behalf of Blue Cross Blue Shield of Michigan, Respondent. On July 22, 2011, the undersigned issued an Order Following Prehearing Conference.

On September 30, 2011, Petitioner filed its Witness and Exhibit Lists. On October 3, 2011, Respondent filed its Witness and Exhibit Lists. On October 25, 2011, the undersigned issued an Order Granting Adjournment, rescheduling the hearing date to January 26, 2012. On February 2, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing date to April 5, 2012.

On April 3, 2012, Attorney Rogalski filed a motion to withdraw as counsel for Petitioner, and also requested on behalf of Petitioner that the April 5, 2012 hearing date be adjourned. Attorney Rogalski's motion indicated that Whole Health Medical Center, P.C. is an assumed name for Robert E. Thompson, M.D., P.C., and that the Blue Cross Blue Shield of Michigan provider and real party in interest is Robert E. Thompson, M.D. Attorney Rogalski's motion further indicated that after diligent search he had not been able to locate Dr. Thompson. Attorney Rogalski moved for an adjournment "so that I can attempt to locate Dr. Thompson to notify him of my withdrawal and to allow him sufficient time to retain another attorney." On April 4, 2012, Respondent filed notice of no objection.

On April 11, 2012, the undersigned issued an Order Allowing Withdrawal of Counsel and Granting Adjournment, which rescheduled the hearing date to June 6, 2012. This Order was sent by certified mail on April 18, 2012, to Dr. Thompson at his last known address of "2578 A – US 27 South, Alpena, MI 49707", and returned by the post office on April 25, 2012, as "Not Deliverable as Addressed Unable to Forward."

On June 6, 2012, the hearing commenced as scheduled. Neither Petitioner nor Respondent appeared at the hearing. No attorney or representative appeared on behalf of Petitioner or Respondent. It was determined by the undersigned on the record that the parties had been properly served with notice of the hearing date, that no adjournment had been requested or granted for the June 6, 2012 hearing date, and that the hearing should proceed under Section 72 of the APA, being MCL 24. 272.

It was further determined by the undersigned on the record that a proposed decision should be issued containing a default against Petitioner as the party with the burden of proof in this matter, pursuant to Section 78 of the APA, being MCL 24.278.

Sections 72 and 78 of the APA state in pertinent part as follows:

> Sec. 72. (1) If a party fails to appear in a contested case after proper service, the agency, if no adjournment is granted, may proceed with the hearing and make its decision in the absence of the party. MCL 24.72(1).

> Sec. 78. (2) Except as otherwise provided by law, disposition may be made of a contested case by stipulation, agreed settlement, consent order, waiver, default or other method agreed upon by the parties. MCL 24.78(2).

No witnesses or exhibits were presented at hearing. The record was closed at the conclusion of the hearing.

ISSUES AND APPLICABLE LAW

The issues presented are whether Respondent has violated Sections 402(1)(a),(b),(c),(d),(e),(f),(g),(l)&(m) and 403 of the Nonprofit Act, *supra,* as alleged in the Petition for a Contested Case Hearing and the Complaint, and further whether Respondent is entitled to a refund from Petitioner for any of the amounts claimed as overpayments. These statutory sections provide as follows:

> Sec. 402. (1) A health care corporation shall not do any of the following:
>
> (a) Misrepresent pertinent facts or certificate provisions relating to coverage.
>
> (b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
>
> (c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
>
> (d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.
>
> (e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
>
> (f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.
>
> (g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
>
> * * *

> (l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.
>
> (m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate. MCL 550.1402(1)(a-g) and (l-m).
>
> Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim. Section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006, applies to a health care corporation.
>
> (2) A health care corporation shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation. This subsection does not apply to a health care corporation when paying a claim under section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006. MCL 550.1403.

A petition for contested case hearing was requested by Petitioner in accordance with Section 404(6) of the Nonprofit Act, *supra,* which provides:

> Sec. 404. (6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act. MCL 550.1404(6).

Rule 108 of the Procedures for Informal Managerial-Level Conferences and Review by Commissioner of Insurance states:

> Rule 108. (1) If the decision by the commissioner or the commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.
>
> (2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.
> 1986 AACS, R 550.108.

FINDINGS OF FACT

Based on the entire record in this matter, including the pleadings and the default ruling against Petitioner, the following findings of fact are established:

1. In October 2003, Blue Cross Blue Shield of Michigan, Respondent, conducted a post-payment review audit of payments made to Whole Health Medical Center, P.C., Petitioner, for the time period of March 1, 2001 to August 31, 2003. [Review and Determination, pp 1-2].

2. The initial refund amount requested by Respondent from Petitioner was $152,724.24. [Review and Determination, p 2].

3. On July 17, 2006, Petitioner requested a review and determination by the Commissioner of Financial and Insurance Regulation regarding its dispute with Respondent. [Review and Determination, p 1].

4. On February 23, 2011, the Commissioner's Designee Susan M. Scarane issued a Review and Determination, in which the Commissioner's Designee found and concluded that Respondent had violated Section 402(1)(f) of the Nonprofit Act, *supra*, and that Respondent's refund from Petitioner should be reduced to $102,178.20. [Review and Determination, p 27].

5. On May 5, 2011, Petitioner submitted a Petition for a Contested Case Hearing to the Office of Financial and Insurance Regulation essentially as an appeal of the Review and Determination, in which

it alleged that Respondent had violated Sections 402(1)(a-g) and (l-m) of the Nonprofit Act, supra, and that Respondent was not entitled to any of the amounts claimed as overpayment as a result of the post-payment audit. [Complaint, p 1; Petition, p 4].

6. The record does not show that Respondent filed a petition for contested case hearing to appeal the Review and Determination of the Commissioner's Designee.

7. On May 10, 2011, Special Deputy Commissioner Randall S. Gregg issued an Order Referring Complaint for Hearing and Order to Respond. The attached Complaint states that a hearing would be "held to determine if the factual allegations are true." [Complaint, p 1].

8. On May 11, 2011, the initial Notice of Hearing was issued. Following the granting of several adjournments, the hearing was scheduled for June 6, 2012.

9. Petitioner did not present any evidence at the hearing held as scheduled on June 6, 2012, in support of its allegations set forth in the Petition for a Contested Case Hearing and the Complaint, and a default ruling was entered against Petitioner and the record closed.

CONCLUSIONS OF LAW

Petitioner, as the complaining party, has the burden of proof in this matter to show by a preponderance of the evidence that Respondent has violated the Nonprofit Act, *supra*, as alleged in the Petition for a Contested Case Hearing and the Complaint, and that Respondent is not entitled to the amounts claimed as overpayment as a result of the post-payment audit. As set forth in the above findings of fact, Petitioner failed to present any evidence at hearing in support of its allegations. Based on the above findings of fact and the default ruling against Petitioner under Section 78 of the APA, *supra*, the undersigned concludes that Petitioner has not met its burden of proof.

In particular, Petitioner has failed to show that Respondent has violated Sections 402(1)(a-g) and (l-m) and/or Section 403 of the Nonprofit Act, *supra,* other than as found by the Commissioner's Designee in the Review and Determination issued on February 23, 2011, or that the findings and conclusions in the Review and Determination should be reversed or modified. Therefore, it is concluded that the Petition for a Contested Case and Complaint should be dismissed.

PROPOSED DECISION

Based on the above findings of fact and conclusions of law, the undersigned Administrative Law Judge proposes the following to the Commissioner:

1. That the above findings of fact and conclusions of law be adopted in the Commissioner's final decision and order in this matter;

2. That the Commissioner's final decision and order dismiss Petitioner's Petition for a Contested Case Hearing and the Complaint, and affirm the Review and Determination issued by the Commissioner's Designee on February 23, 2011; and

3. That the Commissioner take any further action authorized by the Nonprofit Act, *supra*, that the Commissioner deems appropriate to the established facts and conclusions of law.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Office of Financial and Insurance Regulation, Division of Insurance, Attention: Dawn Kobus, P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after exceptions are filed.

Lauren G. Van Steel
Lauren G. Van Steel
Administrative Law Judge

STATE OF MICHIGAN

DEPARTMENT OF ENERGY, LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of:

Whole Health Medical Center

Petitioner

v. File No. 76930

Blue Cross Blue Shield
of Michigan

Respondent
_____/

REVIEW AND DETERMINATION

BACKGROUND

On July 17, 2006, Whole Health Medical Center (Petitioner) requested a review and determination by the Commissioner of Financial and Insurance Regulation (Commissioner) over its dispute with Blue Cross Blue Shield of Michigan (BCBSM), pursuant to Section 404(3) of 1980 P.A. 350, as amended (Act). Petitioner dispute involves audit findings from a post-payment review audit conducted by BCBSM in October 2003.

A meeting of the parties was held on June 6, 2008 at the Office of Financial and Insurance Regulation to discuss the above referenced issues. Gary Saks, D.C. was in attendance at the meeting and was represented by Mr. Alan Rogalski. Mr. Bryant Greene, Ms. Cheri Dancey and David Perry, P.T. represented BCBSM at the meeting. The meeting was presided over by Commissioner's Designee Susan M. Scarane. At the meeting of the parties, BCBSM agreed to re-review the patient records discussed at the meeting of the parties as well as those services denied for no record of procedure (NRP). BCBSM notified Petitioner of its findings on the re-review on November 16, 2009. Petitioner's position paper was received via e-mail on February 22, 2010 and by regular mail on March 1, 2010. BCBSM's position paper was received via e-mail on April 16, 2010 and by regular mail on April 22, 2010. Supplemental information was provided via e-mail by BCBSM on November 5, 2010 and December 2, 2010.

ISSUE

Whether BCBSM violated Sections 402(1)(b-d), (f) and (l) of the Act when it conducted the post payment review audit in October 2003 and demanded repayment of $138,829.07?

AUDIT HISTORY

An audit of Petitioner's records was conducted by BCBSM in October 2003. The audit included a review of services paid during the time period of March 1, 2001 to August 31, 2003. The initial refund amount requested from Petitioner was $152,724.24. A managerial level conference was held on September 30, 2005. After the managerial-level conference, BCBSM reduced its refund request to $138,829.07. The change in the refund request was in part due to a reconsideration of claims associated with the billing of procedure code 97750 (muscle testing) multiple times. BCBSM initially approved the first visit and denied subsequent visits as double billed. BCBSM re-reviewed this issue and determined that it was appropriate to bill this procedure for treatment provided to different areas of the body using modifier 59. As a result, in any case where the first of these services was approved and the rest denied as a duplicate billing (DB), BCBSM approved the DB services. However, if the first service was denied for any other reason such as not meeting BCBSM's documentation guidelines (DG) or for lack of medical necessity (DMN), the remaining services for procedure code 97750 on the same date of service were denied. Also, BCBSM approved services denied for DGS (documentation not signed or dated). All services with this denial code were approved if that was the only reason for the denial. BCBSM notes however that its approval of these procedures does not release Petitioner from the obligation to sign documentation according to BCBSM's guidelines.

At the meeting of the parties, BCBSM agreed to reconsider certain files reviewed and the meeting of the parties and to take all projections out of the refund for wrong code (WC) and no record of procedure (NRP) determinations and recalculate its refund request. BCBSM notified Petitioner on November 16, 2009 that the re-review was complete and that although its denial codes changed for certain services, the changes made had no affect on its overall refund request of Petitioner. Further, BCBSM found that its initial refund letter to Petitioner contained an error. The letter appears to have included a projection for WC and NRP codes of $24,540.92, but in reality BCBSM had neglected to add this projection into its refund request. BCBSM acknowledges its findings letter is incorrect and confusing but contends that there was no projection added to its requested refund. As such, BCBSM continues to request a refund of Petitioner of $138,829.07.

The major issues noted by BCBSM were that:

- Chronic conditions were treated with little or no documentation of change in the patient's condition or recent exacerbations.

- Overall documentation poorly demonstrated objective measures of functional deficits and the status of patients was difficult to determine due to the poor quality of documentation.

- Progress was inadequately documented as part of the patient's evaluation or re-evaluation.

PARTIES' POSITIONS

Petitioner states it is a multi-disciplinary clinic offering chiropractic, medical and physician directed and supervised physical therapy services. Each and every physical therapy service rendered by Petitioner was supervised and monitored by a physician.

Petitioner claims the medical necessity of physical therapy is the central issue in this appeal. BCBSM, in a manner that suggests an alarming disposition on the part of BCBSM to just deny services, denied the majority (77.94% of line items and 79.08% of payments) of physical therapy services rendered by Petitioner during the audit period. According to its cryptic written findings, BCBSM rejected the vast majority of these services based on the alleged lack of medical necessity (DMN). BCBSM also denied a substantial number of services based on Petitioner's alleged failure to meet documentation guidelines (DG) and the alleged billing of services with no order (NO), wrong code (WC), not a benefit (NB) and no record (NR or NRP). Neither the written findings nor the explanations of BCBSM's physical therapist consultant provide the clear, concise and specific explanation for claims denials that is required by the Act.

Petitioner contends BCBSM's physical therapy consultant denied many services for reasons he could not support with any BCBSM guidelines, national protocols or the standard of care. In many cases, BCBSM denied services without even reviewing the documentation in the patient chart. Indeed, it was revealed at the meeting of the parties that BCBSM's consultant did not have an entire section of the patient chart. This is despite the fact that the portion of the chart BCBSM failed to review contained documentation of the services denied for NR, documentation of functional deficits, or documentation that negated BCBSM's consultant's opinion about treating patients with chronic conditions.

The major theme by BCBSM throughout the audit process was the opinion that many of the services were rendered on patients with chronic conditions and/or without documentation of functional deficits. This is despite the fact that all patients discussed at the meeting of the parties had experienced an increase in severity of their conditions, a fact that was documented in their charts. BCBSM claimed it denied the services because documentation of functional deficits before and after the onset was not specific enough. BCBSM's consultant's narrow view of chronicity and exacerbation is not supported by any published guidelines.

Petitioner contends BCBSM's audit findings are also marred by mind-boggling inconsistencies. Services were denied with the same or similar documentation as services that were approved by BCBSM. Perhaps some of the confusion can be explained by BCBSM's consultant's admission at the meeting of the parties that he did not have copies of significant portions of the medical records. And, based on the consultant's comments in his written report and at the MLC and the meeting of the parties, he failed to take into account the multi-disciplinary nature of Petitioner, likely resulting in many inappropriate denials. Regardless, it is impossible to identify any clear BCBSM position from these findings.

Further, BCBSM chose to repeatedly ignore the directives of the Commissioner's Designee to perform a re-review of all NR and NRP services in the audit and to address problems with its extrapolation of services. Inexplicably, BCBSM limited its review to the patients discussed at the meeting of the parties. And rather than provide Petitioner with revised reports showing the re-review results, it provided an indecipherable e-mail in which the Petitioner was advised that its refund request remained unchanged. This was contrary to the Commissioner's Designee's directives to BCBSM and without any justification. For that reason alone, all NR and NRP services in the audit should be approved and any extrapolation thrown out as a flagrant violation of Sections 402(1)(b-d), (f) and (l) of the Act.

Petitioner contends it is entitled to deference with respect to the services it provided to BCBSM members. With regard to denials based upon the decision of BCBSM's physical therapy (PT) consultant as to the medical necessity of the services in question, it is a well-established principle that the treating physician is to be given deference in terms of decisions of medical necessity. In Heller v. BCBSM, No. 84-5798, Eastern Dist of Mich (July 31, 1986), the court stated that "[t]he attending physician's judgment regarding the necessity of treatment should be controlling." The court ruled that this kind of medical determination is better left with the treating physician than a medical consultant who has been hired by the insurer, and who has no knowledge of the patient's case. According to the Heller court, a contrary result would allow BCBSM to arbitrarily second guess a reasonable diagnosis and treatment by the treating physician. (See also Shumake v. Travelers Ins. Co., 147 Mich. App. 600, 383 N.W.2d 259 (1985), where the court held "that a physician's judgment should be accorded deference", and that "a physician is generally better equipped than lawyers and judges to discern what is medically necessary.").

A significant holding in Heller is the court's decision to deter to the judgment of the Plaintiff's treating physician "because Blue Cross did not reserve the right to determine what types of treatments are 'medically necessary' by means of a specific policy exclusion." Heller, p. 8. The Heller court followed the Shumake court, which held that "unless the insurer reserves the right to determine medical necessity by means of a specific policy exclusion, the attending physician's judgment regarding the necessity of treatment should be controlling." Heller, p. 7, *citing* Shumake, 147 Mich. App. 608-209, 383 N.W.2d at 263.

Clearly, since BCBSM pays a PT consultant to make decisions with regard to the reimbursement of medically necessary services, the burden lays with BCBSM to demonstrate that the services were not medically necessary. More importantly, the burden is on BCBSM to demonstrate it has reserved the right to determine medical necessity in this case through a specific policy exclusion.

Petitioner contends BCBSM has not met its burden. Physical therapy services were denied by BCBSM for lack of medical necessity under circumstances where BCBSM did not have direct knowledge of the patient's case nor a relationship with the patient and did not review the entire medical record. What exists in relation to these services is nothing more than a difference of opinion with respect to the medical appropriateness of the services at issue. It is the opinion of Petitioner's physicians that the physical therapy services were medically necessary and that the chart documentation adequately supports this. BCBSM takes the opposite view, without even having reviewed the medical record in many cases and without the benefit of knowledge of the patient's case or any relationship with the patient. Further, there is nothing in the subscriber certificates for these patients that supports BCBSM's denials or excludes from coverage the services rendered.

Under such circumstances, Petitioner believes the treating physician's judgment regarding the medical necessity of physical therapy services is controlling. BCBSM and the Commissioner should provide deference to the judgment of these physicians. Further, where a determination needs to be made as to whether Petitioner was treating a patient with a chronic condition versus a situation where there had been an exacerbation of a chronic condition, Petitioner's judgment in this regard is entitled to deference.

This principle also applies in other types of medical judgment. In Allen v. Califano, 613 F.2d 139 (6th Cir. 1980), the court held that "[t]he reports of physicians who have treated a patient over a period of time or who are consulted for purposes of treatment are given greater weight than are reports of physicians employed and paid by the government for the purpose of defending against a disability claim." This principle seems particularly applicable in this case, where it was revealed at the meeting of the parties that BCBSM's consultant reports were based on a review of incomplete medical records.

Petitioner states it was revealed at the meeting of the parties that BCBSM's consultant did not review an entire section of the chart (the chiropractic section) that contained documentation of the services denied for NR and NRP. Given this revelation, the Commissioner's Designee directed BCBSM to re-review all NR and NRP denials in the audit, revise the denials if the records were present and provide revised audit reports. Despite multiple extensions of time, BCBSM failed to comply with this directive. Instead, it merely reviewed the services within the patient charts presented at the meeting of the parties, swapping the NR and NRP denials for other denial codes, with little to no explanation for the changes. BCBSM failed to even supply Petitioner with revised audit

reports reflecting these changes. For this reason, all NR and NRP denials in the audit should be reversed and approved.

Petitioner states another issue in this appeal is BCBSM's application of a statistical extrapolation on a sample of claims denied. At the meeting of the parties, BCBSM was instructed by the Commissioner's Designee to perform a re-review and also to back certain denial codes (including WC denials) out of the extrapolation. After several months and multiple extensions of time to provide it, BCBSM offered the following in its November 16, 2009 e-mail to Petitioner's counsel and the Commissioner's Designee with regard to its "revised" extrapolation:

> "[redacted] completed his re-review of the records for the patient[s] discussed at the Review and Determination meeting. No changes were made that would affect the refund. Specifically, for [redacted] we changed services that were denied NO to NSP. For [redacted] we changed services that were denied NRP to NO. Finally for pt [redacted], we changed the service that was denied NRP to SNQP (service by a non-qualified provider). These are the changes [redacted] recommended that we make. As indicated above, these changes had no affect on the refund.
>
> Additionally your e-mail dated November 12, 2009 you state: "In addition, independent of this issue, BCBSM was supposed to back the procedures identified as "WC" out of the statistical extrapolation". If you review the calculations on page 2 of the attached audit letter dated June 17, 2004, you will note there were no projections added to the refund amount. Unfortunately the letter above the calculation section clearly states an additional recovery of $24,540.92 was added to the refund amount. However, the identified overpayment was $152,724.24. That amount did not change from the total requested refund amount. Clearly this is confusing, but it is equally clear the projected amount of $24,540.92 was not added to the identified refund.
>
> Sorry for the delay in getting this information to you. Let me know if you have any questions or need additional information."

There are two problems with BCBSM's attempt to explain the extrapolation. First, the "projected amount" of $24,540.92 was, in fact, added to the identified refund. Second, this "explanation" fails to even acknowledge the fact that the overall demand was reduced to $138,829.07 following the MLC in this matter.

A review of the MLC results reveals that BCBSM failed to even mention the extrapolation, let alone provide any explanation as to the effect the approvals of services following the MLC had on the extrapolation. Following the MLC, Petitioner was never provided with any

information regarding any revised extrapolation, nor any details regarding how the revised findings impacted the extrapolation.

Contrary to BCBSM's assertions, if we are to accept the audit demand at face value, through the application of a statistical projection, BCBSM claimed it was owed an additional $24,540.92. And additional information provided to Petitioner in connection with BCBSM's extrapolation is scant at best. Despite Petitioner's requests, BCBSM has been unwilling or unable to produce sufficient information regarding its original statistical sampling and extrapolation. In response to Petitioner's request for "any and all documents related to the projected overpayment, including all documents relative to the statistical sampling methodology used, and any and all documents or working papers used in the projection," Petitioner received four pages of canned information, but nothing more which would explain how BCBSM arrived at this figure. Without more, it appears that there was an additional $24,540.92 added to the demand as a result of a projection.

Petitioner contends that at the meeting of the parties, the Commissioner's Designee ordered BCBSM to complete a re-review of records, including a review of records for services that were denied by BCBSM as NR or NRP (denial codes that are extrapolated). This was because it was revealed at the meeting of the parties that the documentation for these NR and NRP services was contained in a portion of the chart not reviewed by BCBSM's consultant. Further, the Commissioner's Designee specifically directed BCBSM to back all WC services (also extrapolated) out of the extrapolation. BCBSM failed to do this. BCBSM's response to the directive of the Commissioner's Designee to back out the WC denials and re-review all NR and NRP services in the audit was to maintain its MLC findings (presumably at $138,829.07).

Considering BCBSM's statement in the audit results that the "projected overpayment" is $24,540.92; BCBSM's failure to properly account for the extrapolation in its MLC results; and BCBSM's failure to follow the directive of the Commissioner's Designee to back certain services out of the extrapolation, the entire extrapolation should be thrown out. Therefore, the amount at issue in this review and determination should be $114,288.15, calculated by subtracting the full amount of the extrapolation ($24,540.92) from the MLC results ($138,829.07).

Petitioner states that throughout this appeal process, BCBSM has given a variety of reasons for denying the physical therapy services rendered by Petitioner. However, the primary reason accounting for the majority of BCBSM's denials was the opinion of BCBSM's physical therapy consultant that the services were rendered on patients with chronic conditions and without documentation of functional deficits. This is despite the fact that all patients discussed at the meeting of the parties had experienced an increase in severity of their conditions, a fact that was documented in their charts. BCBSM claimed it denied the services because documentation of functional deficits before and after the onset was not specific enough.

Unfortunately for BCBSM, this narrow view of documentation, chronic conditions and exacerbation is not supported either by written guidelines or common sense. Further, Petitioner has demonstrated that its documentation is consistent with BCBSM policies in connection with physical therapy services, relevant national protocols and the standard of care. BCBSM was not able to support its conclusions as it appears BCBSM is requesting a level of documentation not required by BCBSM's own documentation guidelines.

Based on the BCBSM's consultant's comments at the MLC and meeting of the parties and a review of his written report, it did not appear that the consultant understood that Petitioner was a multi-disciplinary practice combining medical, physical medicine and chiropractic services. The consultant's confusion was probably best demonstrated by his failure to even review an entire portion of the medical record because it was contained in the chiropractic portion of the chart. Further, it did not appear that the consultant understood that a medical doctor was involved on each and every date of service, evaluating every patient and supervising each physical therapy service with far greater frequency than that required by BCBSM when physical therapy is provided by an independent physical therapist in a location other than in a physician's office.

BCBSM states its physician documentation guidelines were published in the March 1, 1992 edition of the *Record*. The *Record* indicates all services provided must be generally accepted as necessary and appropriate for the patient's condition and not be ordered on a routine basis. All aspects of patient care information regarding the need for, results of and use of information from physician's services must be legibly documented in the patient's medical records. The medical record must serve to chronologically document the patient's medical history in sufficient detail to ensure the patient can receive high quality care in the future and to allow fair and accurate review of physician services by third party payers.

The *Record* further states that medical records must contain documentation of a relevant diagnosis and/or a concern related to management of the patient's condition to justify the performance of all tests and procedures. In addition, the documentation must contain sufficient information regarding the patient's history including current symptoms, medical history, family history and objective clinical findings including the physical exam findings and other diagnostic test results." The patients' medical records must also indicate that the physician interpreted the results of the test and used those results in the management of the patient.

The documentation guidelines also included in BCBSM's *Guide for Providers of Physical Therapy, Occupational Therapy, and Speech and Language Pathology Service (Guide)* indicate that:

> "Physical therapy is the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following

surgery. Treatments include exercise, physical agents and therapy of the patient's specific muscles or joints to restore or improve the following:

- Muscle strength
- Joint motion
- Coordination
- General mobility"
-

BCBSM contends the documentation in Petitioner's records illustrated that chronic conditions were treated by Petitioner with little or no documentation of change in condition or recent exacerbations. Also, the documentation in the patient record did not demonstrate objective measures of functional deficits, and the status of patients was difficult to determine due to the poor quality of documentation. Progress was poorly documented as part of the patient's evaluation or re-evaluation.

Several patient files were discussed at the meeting of the parties. Petitioner's and BCBSM's position on these records are outlined below.

Case # 1 [redacted]

Petitioner states this patient is a 38 year old female who presented with sharp low back pain for about one week that was accentuated with bending, lifting and transitioning from sitting to standing (obvious functional deficits). In addition, she complained of neck pain that started the previous day that she graded at a 4 to 6 on a scale of 1 to 10. Her treatment began on May 30, 2003 and she was released from care August 20, 2003.

Computerized range of motion (ROM) testing done on June 4, 2003 revealed reduced ROM with cervical extension (57 degrees), right lateral (40 degrees) and rotation (66 degrees), as well as decreased ROM in lumbar extension (12 degrees). Computerized muscle strength testing also showed reduced strength in the right anterolateral cervical flexion, right hip flexion and right knee flexion.

Petitioner notes that these tests were repeated July 25, 2003, showing measurable progress (cervical right lateral 42 degrees, cervical rotation 79 degrees).

Examination also revealed a positive Adson's sign (indicating possible thoracic outlet syndrome) and muscle spasm in the upper and middle trapezious, sternocleidomastoid (SCM), sub occipital and scalene muscles. The patient also showed a positive Yeoman's sign (indicating a left sacroiliac [SI] joint ligament strain); and spasm in the erector, Quadratus Lumborum (QL), piriformis, gluteal medial and gluteal maximus muscles. The patient stood with a forward and to the right antalgic position. The psoas muscle strength was noted as a grade 4.

Petitioner states BCBSM denied every single service rendered to this patient during the audit period for not meeting BCBSM's documentation guidelines, with the exception of dates of service July 7, 2003 through July 30, 2003, which were denied for no order (NO). BCBSM's rationale for denying these services, including the "only provider identified is a chiropractor" and there was no order for the service (NO). BCBSM also alleged that there was no ongoing progress documented, and that the treatment was for pain without documented loss. At the meeting of the parties, BCBSM's consultant reverted to his fallback position that there was insufficient documentation of functional deficits. Petitioner contends that a medical doctor had signed or initialed every order, every daily note and every evaluation.

Petitioner also contends that there are subjective and objective notes for every day of service. Comments like increased ROM, reduced hypertonicity, "patient did exercises without problem," etc., are written throughout the file. With respect to BCBSM's no order denials, BCBSM is putting form over substance, ignoring the multi-disciplinary nature of this practice, and attempting to morph Petitioner into an independent physical therapy practice. BCBSM is basing its denials on the fact that the order dated May 30, 2003 was for 12 weeks (but expired after 30 days, at the end of June). However, BCBSM is ignoring the fact that on every day of treatment from June 30, 2003 to July 30, 2003, Dr. Thompson demonstrated his daily involvement with and evaluation of the patient's treatment by documenting that the physical therapy was "per script". Common sense dictates that if, in the provider's professional judgment, a change in the treatment plan was necessary, the provider would have documented it there. More importantly, this documentation effectively serves as a new order on a daily basis.

In addition, BCBSM's documentation guidelines indicate that "the physician must document the need for physical therapy services during the initial referral and during periodic evaluations (i.e., at least every 60 days)." There is no question that Petitioner complied with this.

Lastly, with regard to BCBSM's "fallback" position that functional deficits were not documented, as identified above, the patient had difficulty with bending, lifting and transitioning from sitting to standing, had decreased range of motion as identified with computerized range of motion testing, and had decreased muscle strength as identified on computerized muscle testing. Petitioner contends all services rendered for this patient should be approved.

BCBSM states it was billed for physical therapy for the period May 30, 2003 through August 20, 2003. BCBSM denied the services for dates of service May 30, 2003 through June 30, 2003 as DG (not meeting its documentation guidelines). Dates of service July 7, 2003 through July 28, 2003 were denied as NO (no order). The remaining dates of service were denied as not meeting BCBSM's documentation guidelines. BCBSM contends the records for this patient lacked documentation of an ongoing progress report.

Based on the patient registration and history form the patient filled out, this patient had low back pain and stiffness. BCBSM was then billed for five physical therapy procedure codes. In denying these procedures BCBSM notes Petitioner did not indicate the patient's functional deficit. The records indicate the patient's ROM was within functional limits and the strength was 4/5. BCBSM states it could not determine what limitations this patient actually had.

BCBSM's *Guide* states "physical therapy is the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness, injury, or following surgery. Treatments include exercise, physical agents and therapy of the patient's specific muscles or joints to restore or improve the following:

- Muscle strength
- Joint motion
- Coordination
- General mobility"

Clearly with no documentation of a functional deficit the claims for dates of service May 30, 2003 and June 2, 2004 were appropriately denied.

The next evaluation by Petitioner appears to have taken place on June 4, 2003. The cover sheet indicates injuries of headaches and back pain with diagnoses of low back pain and functional muscle weakness. However, a review of the computerized muscle testing exam revealed that all muscles were within their functional limits and thus, the services provided during June 2003 were appropriately denied.

BCBSM states the evaluation of June 4, 2003 expired after 30 days. It is BCBSM's position that no order was provided to support dates of service July 7, 2003 through July 28, 2003. As such, those dates of service were denied with the denial code NO.

Another order was in the patient file dated July 30, 2003 which allowed for eight weeks and sixteen visits of therapy. This order covered the remaining visits in the audit, July 30, 2003 through August 20, 2003. These dates of service were denied as not meeting BCBSM's documentation guidelines. This evaluation did not provide for functional deficiencies that would justify the physical therapy procedure provided. This sheet has several "X" in boxes that describe a goal and the vertical listing appears to indicate the method that will be used to achieve the goal, but the document does not indicate the limitations the patient is experiencing. For instance, an "X" is included in the box "Increase ROM". Apparently this will be accomplished by traction, therapeutic exercises, massage, joint mobilization, manual therapy and kinetic activities. However, the records fail to indicate what the ROM was prior to these treatments. The same can be said for the column entitled "Improve Gait". Without some baseline measurements it is not possible to determine if the patient was actually improving.

Case # 2 – [redacted]

Petitioner states this patient was a 45 year old female nurse who presented with mid and low back pain. The initial exam performed on July 25, 2002 revealed reduced ROM in all planes in the lumbar spine. Spasm was noted in the erector and QL muscles bilaterally. Decreased ROM was also noted in the cervical spine in all planes, as was a muscle spasm in the suboccipital, SCM, upper trapezious and the middle trapezious muscles. On a pain scale of 1 to 10, the patient rated her pain varying from 5 to 8. She described her discomfort as aching and shooting with numbness, tingling and stiffness. The patient described her pain as constant and daily. The pain was more evident with sitting, walking and bending. The patient's job was a home health care provider. Her work required her to sit while driving and to stand with light labor. The patient's treatment began on August 13, 2002 and ended on October 17, 2002. She then had one treatment about two months later, on December 6, 2002 and then about seven months later, received treatment on July 25, 2003 and July 28, 2003.

BCBSM denied every single service rendered to this patient during the audit period as not meeting its documentation guidelines. Among BCBSM's reasons for denying the services was that there was no initial evaluation to determine functional loss. BCBSM also alleged that there was no ongoing progress documented as well as its own standby that there was insufficient documentation of functional deficits.

With regard to BCBSM's allegation that there was no initial evaluation to determine functional loss, apparently it missed the documentation in the chart of the evaluation done on July 25, 2002 that revealed reduced ROM in all planes in the lumbar spine; that spasm was noted in the erector and QL muscles bilaterally; that decreased ROM was also noted in the cervical spine in all planes, as well as muscle spasm in the suboccipital, SCM, upper trapezious and the middle trapezious muscles; that on a pain scale of 1 to 10, the patient rated her pain varying from 5 to 8; that the patient described her discomfort as aching and shooting with numbness, tingling and stiffness, and her pain as constant and daily and more evident with sitting, walking and bending – all functional deficits, especially in an individual whose work required her to sit while driving and to stand with light labor.

Perhaps BCBSM was critical of the fact that the patient's schedule did not allow her to begin a consistent treatment program until August 13, 2002. However, in addition to the documentation on July 25, 2002, on August 13, 2002, the patient reported her condition progressively getting worse, with numbness, aching, shooting, tingling and stiffness. The patient also reported that the pain was daily and constant, and that her activities of sitting, walking and bending were painful to perform.

Notes from the chiropractic section of the chart on September 17, 2002 state, "hypertonicity in cervical, thoracic and lumbar paraspinal muscles bilaterally, increased

trigger point activity in bilateral upper trapezius, levator scapula and rhomboid muscles bilaterally." There are similar notes on September 30, 2002.

Petitioner states the following information refutes BCBSM's allegation that there was no ongoing progress documented in the patient chart:

- August 22, 2002 PT note: Pain isn't as intense as when patient first originally came. ROM slightly improved. Gross muscle strength is slightly improved.

- August 28, 2002 PT note: The patient's ROM in the low back has decreased from her last visit. This is due to muscle guarding and splinting and overall pain. The patient's upper back and cervical spine motion has improved.

- September 3, 2002 PT note: Overall posture and gait in this patient has improved as the shoulders have rolled back and there seems to be more retraction of the neck.

- September 19, 2002 Computerized Testing revealed:

    - Cervical ROM L Lateral 40 (normal 45), R lateral 31 (normal 45)

    - Muscle strength:

        - Deficit of 24% right hip flexors from 90* (psoas)
        - 33% deficit R hip flexor from 0*
        - 6% deficit R semitendenosis
        - 13% deficit L elbow extension
        - 8% deficit L elbow flexion
        - 8% deficit L wrist extension

- September 30, 2002 Chiropractic note: States decrease in hypertonicity and trigger points.

- October 11, 2002 Chiropractic note: Same as the previous visit.

- October 11, 2002 PT note: Strength endurance has improved, though actual strength has not shown signs of dramatic improvement and still lies beneath normal.

- October 16, 2002 PT note: Muscles of the mid back and shoulder region have relaxed somewhat. The patient's ROM is less guarded and mechanical.

Petitioner contends all these entries and others contained in this patient's records document the patient's ongoing progress. All services rendered by Petitioner for this patient should be approved.

BCBSM states it is seeking a refund for claims billed for dates of service August 16, 2002 through July 28, 2003. BCBSM denied the services as not meeting its documentation guidelines. BCBSM concluded the services were for a chronic condition without documentation of a recent exacerbation, and therefore not a payable benefit. Further, the documentation is lacking an initial evaluation to establish a baseline for services. This patient record also lacked documentation of functional loss.

On the August 13, 2002 patient registration and history form the patient indicated the reason for her visit was for back pain. The next line of the form asked when the symptoms appeared the patient indicated that she'd been having problems for 24 years. BCBSM states that under the section entitled Non-Covered Services in the *Guide* it clearly indicates that BCBSM does not pay for "therapy for pain management or treatment of long-standing chronic conditions." It is BCBSM's position that this patient's condition was chronic and therefore not a payable benefit. In fact, documentation of the patient examination indicates that the patient came in for the evaluation and treatment of her low back pain, which the patient indicates was a chronic condition because the patient had some scoliosis in her back. The progress notes covering the period August 22, 2002 through October 17, 2002 clearly substantiate that no exacerbation occurred during the audit period that would justify the services billed.

Case # 3 – [redacted]

Petitioner states this patient is a 19 year old football player who presented to Petitioner on May 2, 2003 with low back pain. He rated it 6 or 7 on a pain scale of 1 to 10. The pain came after physical activity and was aggravated by standing. The patient described the pain as throbbing, aching and was accompanied by stiffness. The pain would come and go, but was worse after physical activity. The patient stated the pain interfered with his daily routine and that standing was painful (obvious functional deficits). The patient was treated successfully and released from care on July 25, 2003, in less than three months, and was completely recovered.

BCBSM denied every single service rendered to this patient during the audit period for DMN, WC or NRP. These services were denied by BCBSM because it believed there were no functional limits documented except pain; that objective measures of deficits were absent; and that medical necessity was not established because the patient had a chronic condition. BCBSM also alleged that ongoing documentation of progress was lacking and that in some cases there was no record of the procedure.

Initially, it was in the context of discussing this patient case that BCBSM was directed to review all NRP services and reverse the denial if the records were present. BCBSM was also directed to back all WC denials out of the extrapolation. BCBSM, without any justification, failed to do this.

With regard to BCBSM's arguments that there were no functional limits documented except pain; that objective measures of deficits were absent; and that medical necessity was not established for a chronic condition, Petitioner states the following documentation is pertinent:

- May 2, 2003 evaluation indicated bilateral muscle spasm and tenderness in the erector, QL, piriformis and gluteal muscles. Yeoman's test was positive indicating SI joint ligament strain. Lumbar ROM was abnormal.

- May 14, 2003: Computerized ROM was performed and showed imbalance between the left and right lumbar lateral ROM, lumbar flexion was mildly reduced at 57 degrees and lumbar extension was significantly reduced at 13 degrees. The straight leg raiser was reduced for his age at 69 degrees left and 78 degrees right.

With regard to BCBSM's argument that ongoing documentation of progress was lacking, Petitioner states the following documentation is pertinent:

- June 6, 2003: Comparative computerized testing was performed showing improvement in the left lateral, flexion, extension and leg raiser ROM.

- Daily notes document both subjective and objective assessment each day. Comments like "everyday pain has decreased", "strength increased", "able to perform exercise with more ease" and "able to increase weights."

- June 23, 2003 chiropractic notes show an increase in range of motion.

With regard to BCBSM's argument there were no record of the procedures, BCBSM was directed to re-review all such services and revise the denials if the records were present. BCBSM failed to comply with this directive. At the meeting of the parties, Petitioner demonstrated all of the services denied for NRP were recorded in the daily chiropractic log (in this patient case, the NRP services were mechanical traction services).

Further, comparing this chart to the charts of the two patients discussed below ([redacted] and [redacted]) show the inconsistencies that exist between approvals and denials by BCBSM, as the services with the same or similar documentation were approved for those two patients but denied for this patient. Petitioner believes all services rendered to this patient should be approved.

BCBSM states the dates of service in question were May 2, 2003 through July 23, 2003. BCBSM denied these services using denial codes DG/DMN (documentation guidelines and/or lack of medical necessity), WC (wrong code), NRP (no record of procedure), and NSP (not separately payable). The majority of services were denied DG/DMN because BCBSM determined the lower back pain the patient was experiencing was chronic. BCBSM notes the patient registration and history indicates the reason for the patient's visit was low back pain that started in Fall 2001. BCBSM states that treatment for a chronic condition is not a covered benefit and not payable. There is no documentation of a recent exacerbation that would justify the services provided in 2003.

BCBSM denied procedure code 97012 (mechanical traction) with denial code NRP. BCBSM reviewed this chart again after the meeting of the parties and revised the denial code to NO (no order). BCBSM's documentation guidelines indicate that the physician's order should include, among other things, the type of treatment or treatments to be provided. BCBSM contends that in the initial order for this patient traction is simply not indicated as an ordered service so it believes it appropriately denied the procedure as having no order.

BCBSM notes that it did not project the audited error found to the population. Therefore, its denial as DG/DMN and NO do not change BCBSM's refund request from Petitioner. BCBSM also changed procedure code 97032 to 97014 based on the documentation in the patient record. The patient daily treatment form for this patient lists several procedure codes billed by Petitioner. However, nowhere on the form does it indicate procedure code 97032 as an option for billing.

Case # 4 – [redacted]

Petitioner states this chart was presented to demonstrate the inconsistencies between approvals and denials. All services rendered to this patient (except a few services coded NRP) were approved by BCBSM. As was revealed at the meeting of the parties, these services were approved with the same medical findings, necessity and documentation of functional loss as the other patient charts discussed at the meeting of the parties.

BCBSM states it is seeking a refund for procedure code 97012 (mechanical traction). BCBSM denied the procedures for no record of the procedure (NRP). The documentation provided only the initials of the provider, without any parameters of the traction (time, intensity, patient response, etc.) being documented. BCBSM states this type of information is normally included in the daily treatment note accompanying the log. For this patient, no such documentation was provided. Without an accompanying daily progress note that includes this information, BCBSM cannot accept a stand alone log as evidence of performance.

BCBSM also noted flexion distraction was only documented on the chiropractor's notes without the medical doctor's co-signature. Additionally, the physical therapy notes do not include traction as a procedure provided.

Case # 5 – [redacted]

Petitioner states this patient was a 53 year old female who had been sledding and hit a tree. She described pain in her neck, right shoulder and mid back. The patient's pain was aching and constant. The pain interfered with work, sleep, daily routine and recreation (clear functional deficits). It was painful for the patient to bend. On the pain scale of 1 to 10, the patient's pain was a 5. The patient began treatment on March 5, 2003 and was successfully released from care on June 23, 2003.

BCBSM denied every single service provided to this patient during the audit period for lack of documentation guidelines, with the exception of certain dates of service, primarily those after May 12, 2003, which were denied for NO. BCBSM had alleged that there was "no ongoing progress documented," and that this was "treatment for pain without functional loss." BCBSM also alleged there were no orders as of April 7, 2003 for procedure code 97530 (kinetic activities) and no valid orders after May 13, 2003 due to lack of frequency, duration and incomplete orders.

With regard to BCBSM's argument that ongoing documentation of progress was lacking, Petitioner states the following documentation is pertinent:

- March 5, 2003 evaluation: revealed spasm of the SCM, Scalenes, UT and Mid Trap on the right. Right lateral flexion of the neck revealed a decrease in ROM from a normal of 40 degrees to 20 degrees. In addition, at 20 degrees she experienced pain. X-rays revealed a shoulder separation. Edema is noted with the comment "therapy for swollen/inflamed muscles." The number of tests performed was limited by the fact that she had a shoulder separation.

- April 7, 2003 evaluation: shows moderate tenderness, hypertonicity and restriction with pain radiation from the neck to the SCM on the right.

- Medical exam of April 17, 2003 shows restricted ROM in all planes in the right shoulder, and positive orthopedic "Apley's Scratch" and "Apprehension" tests. Also, palpation revealed tenderness and hypertonicity.

- Computerized muscle testing done on May 13, 2003 (the first time she was able to resist with force) revealed weakness on the right: Shoulder flexion, 22% deficit; shoulder abduction, 13% deficit; shoulder extension 19% deficit; shoulder abduction, upper, 21% deficit; and shoulder medial rotation, 13% deficit.

- Computerized muscle testing on June 20, 2003 (four weeks later) showed significant improvement in the strength of all muscle groups.

As discussed by Petitioner at the meeting of the parties, the patient's shoulder separation and also loss of strength, which was copiously documented as described above, are functional losses. The above tests were done prior to Petitioner changing the treatment to more active protocol. Further, for every day of treatment, the documentation shows "improved, worsening or no change" for pain, tenderness, strength, overall condition, trigger points, stamina, ROM, guarding, response to treatment, spasms and swelling. For example, the medical progress note on March 7, 2003 states, "doing better, pain not as bad."

With regard to BCBSM's argument that there were no orders as of April 7, 2003 for procedure code 97530 (kinetic activities), these services were ordered on a daily basis. A review of the documentation, under "services ordered" on each date of service this was billed, shows that this service was ordered on these dates.

With regard to BCBSM's argument that there were no valid orders after May 12, 2003 due to "lack of frequency, duration, incomplete orders," there is, in fact, documentation of orders on each date of service. As argued above, BCBSM is putting form over substance, ignoring the multi-disciplinary nature of this practice, and attempting to morph Petitioner into an IPT practice. BCBSM is ignoring the fact that on every day of treatment, the physician was actively involved in the care of this patient. The documentation demonstrates that the physician was active in watching her in the strength building phase (after the patient was unable to use her shoulder for three months). When the physician saw her strength coming back, he ordered a strength test to confirm it. The physician then documented her normal strength and released her from care with home exercise the very next visit she was in the office. This documentation effectively serves as a new order on a daily basis. Petitioner contends all services rendered to this patient should be approved.

BCBSM states for this patient BCBSM is seeking a refund for dates of service March 5, 2003 through June 23, 2003. The services were denied for either not meeting BCBSM's documentation guidelines or for no order. BCBSM contends that this patient was being treated for pain management without functional loss. BCBSM states there was also no order as of April 7, 2003 for procedure code 97530. There were also no valid orders after May 12, 2003 because the order lacked frequency and duration.

BCBSM states its physical therapy guidelines indicate that physical therapy is the use of specific activities or methods to treat disabilities when there is a loss of neuromusculoskeletal function. Additionally, these guidelines state that therapy for pain management or treatment for long standing chronic conditions is not a covered service. Finally, the physician's order must contain date of order, diagnosis or diagnoses, type of treatment or treatments to be provided, body or areas to be treated, frequency of

treatment, duration of treatment, changes in treatment plan or orders to continue treatment and physician's signature. It is important to note BCBSM's physical therapy guidelines provide that physician orders expire after 30 days.

This patient had a skiing accident and hurt her shoulder. BCBSM states that functional limitation is defined as any health problem that prevents a person from completing a range of tasks, whether simple or complex. BCBSM denied the services for this patient because the records did not illustrate a functional loss. BCBSM's guidelines require, among other things, a description of current status of functional level, including:

- Transfer and ambulatory ability
- Type and amount of physical assistance required
- Equipment and assistive devices used by the patient
- Transfer method
- Gait pattern
- Distance capability
- Muscle strength (graded)
- Range of motion measurements
- Description of the patient's functional level prior to the onset of the current illness or injury

Because this pertinent information was missing from the progress notes for this patient, the services provided were denied as not meeting the documentation guidelines. With a lack of documentation of functional loss, it was correctly concluded the treatment received by the pain were for pain management.

Many other services were denied by BCBSM because of the lack of a valid physician order. BCBSM noted the orders in the medical records were not valid because they lacked frequency, treatment or duration. BCBSM contends there were two orders in the patient record. Of the two orders, the latest, dated April 7, 2003, expired on May 6, 2003. As such, the physical therapy services after May 6, 2003 were appropriately denied as no order. Further, the "Computerized Muscle Testing Exam" dated May 13, 2003 indicated this patient's shoulder was within her functional limits.

Case # 6 – [redacted]

Petitioner states that 66 out of 75 services rendered to this patient were approved by BCBSM. This chart was presented to demonstrate the inconsistencies between approvals and denials. As was revealed at the meeting of the parties, these services were approved with the same medical findings, necessity, and documentation of functional loss as the other charts discussed at the meeting of the parties.

By way of history, these services were originally denied by BCBSM, with the original rationale being, in part, that it was unclear whether the chiropractic evaluation on September 23, 2002, which established medical necessity, was initialed by a physician. When it was shown at the MLC that the form was, in fact, initialed by a physician, most of the services were approved. This procedure (the exam being done by a chiropractor under the orders and approval of the physician) is the same as many other charts in this audit where the services were denied.

Further, as discussed at the meeting of the parties, the findings in the exam for this patient were:

- ROM lumbar and left lower extremity, not measured, restrictions in all planes
- Left the piriformis moderately hypertonic, lumbar paraspinals hypertonic.

BCBSM claims it approved the majority of the services here because there was documentation of objective functional loss in the patient chart. However, BCBSM was not able to explain at the meeting of the parties how the documentation here differs from other patient charts in the audit where the services were denied. BCBSM indicated it would attempt to address the differences in its position paper. Petitioner was particularly interested in an explanation as to why these services were approved when the services rendered to patient [redacted] were denied. A review of these charts shows the documentation is strikingly similar to [redacted] and [redacted], above.

Petitioner states the nine procedures denied for this patient were mechanical traction services with the explanation of NO (no order and not on progress note). In fact, these services are on the order, as documentation of "flexion/distraction" demonstrates. Petitioner contends all services rendered to this patient should be approved.

BCBSM states that for this patient BCBSM is requesting a refund for nine dates of service. For all dates of service, with the exception of October 25, 2002, BCBSM was billed for mechanical traction (procedure code 97012). For date of service October 25, 2002, BCBSM was billed for electrical stimulation (procedure code 97014). BCBSM denied all these procedures as no order (NO). BCBSM's documentation guidelines indicate that the physician's order should include, among other things, the type of treatment to be provided. BCBSM states that in the therapy ordered section of the order, traction is not checked. Additionally, there is no indication of a diagnosis. Thus, BCBSM contends it was correct in denying the traction procedures. BCBSM acknowledges it was probably oversight that BCBSM denied procedure code 97014 as no order because therapy was ordered by the physician.

During the meeting of the parties, it was agreed that BCBSM would compare the denials of this patient to patient [redacted]. BCBSM's consultant re-reviewed the documentation for both patients. After the re-review, BCBSM's consultant determined that the NO denial should

be changed to a NSP (not separately payable) denial. BCBSM believes the procedure done was included in the payment of a previously performed procedure. Petitioner's progress notes for the September 25, 2002 date of service indicates the plan is:

> "The patient received electrical stimulation 80-150 hertz of continuous frequency, both channels were utilized for a time duration of 10 minutes. Hot pack was applied concurrently with electrical stimulation to the area of the left piriformis.
>
> The patient also received manual therapy consisting of tripper point therapy and myofascial release techniques done to the left hip musculature and gluteal musculature."

In denying the mechanical traction services, BCBSM noted the procedures performed fall under procedure code 97140 with no record of mechanical traction. The nomenclature for procedure code 97140 includes manual traction. With the exception of dates of service September 24, 2002 and October 25, 2002, BCBSM was billed both procedure codes 97012 and 97140. For each of the dates of service in question, BCBSM approved procedure code 97140 but denied procedure code 97012 as manual traction is part of manual therapy. There was no indication of mechanical traction in the patient record. A review of the other dates of service in question for this patient revealed the same treatment plan. As such, BCBSM contends it correctly allowed for procedure code 97014, but not for procedure codes 97140 and 97012.

BCBSM states that after the re-review of this patient's records after the meeting of the parties, BCBSM ultimately concluded the only changes in its denials should be changing the NRP denials to NO. In the therapy ordered section, traction is not checked. BCBSM contends there is no indication of the diagnosis, thus it believes it was correct in denying the traction procedures as no order. This determination is completely different than patient Matts. BCBSM contends it is important to note that for both patients, the denials could have been no order based on the therapy ordered section because traction is not checked for either patient. However, BCBSM was not billed procedure code 97140 at all for patient Matts – that is the distinction between the two patients.

DECISION

Sections 402(1)(b-d), (f) and (l) of the Act prohibit BCBSM from:

b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

c) Failing to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

d) Refusing to pay claims without conducting a reasonable investigation based upon the available information.

f) Failing to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

l) Failing to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

With these statutory provisions in mind, based on all of the relevant information available to the Commissioner's Designee, the following determinations are made:

1. The BCBSM documentation guidelines pertinent to this review and determination were published by BCBSM in its March 1, 1992 issue of the *Record* and are described in BCBSM's *Guide for Providers of Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services (Guide)* issued in March 1999. The following provisions are included in the *Guide* under the section entitled "Covered Services":

   > Covered physical therapy must be skilled, comprehensive and intensive. It includes the services listed below (the list is intended as a guideline). These services may not be covered by all groups in all circumstances. If there is a difference between what is listed here and what is noted on the patient's BCBSM contract, the information on the contract applies.

   - Initial evaluation to develop a total treatment plan
     - Isokinetic extremity testing
     - Muscle testing (manual only)
     - Evaluation with test and measurement
     - Extremity testing with instrumentation
   - Basic exercises such as active, resistive and manual stretching techniques
   - Advanced or therapeutic exercise
     - Coordination exercise
     - Postural exercise
     - Isokinetic exercise
     - Stabilization exercise
     - Developmental exercise
     - Skilled and intensive pool therapy
     - Exercises requiring specialized equipment

- Manual therapy
    - Joint mobilization
    - Myofascial release
    - Craniosacral therapy
    - Soft tissue mobilization
- Functional activities
    - Mobility activities
    - Mat and balance activities
    - Transfer techniques
    - Reaching or grabbing activities
    - Prosthetic training
    - Gait training
    - Activities of daily living
- Kinetic therapy or activities
- Spinal or joint manipulation
- Neuromuscular reeducation
- Traction (pelvic or cervical, manual or mechanical)
- Whirlpool or hydrotherapy only when provided as follows: In conjunction with a total intensive treatment program for a neuromuscular disorder or for third-degree burns
- Acute care for recent sports-related injuries
- The following physical agents only when performed in conjunction with a total intensive musculoskeletal treatment program:
    - Cold or ice packs
    - Cryotherapy
    - Diathermy
    - Electrical muscle stimulation
    - Hot packs
    - Infrared heat
    - Iontophoresis
    - Massage
    - Paraffin bath

- Phonophoresis
- Ultrasound

2. Under the payment criteria for physical therapy services, the *Guide* indicates the services provided must be for a diagnosis that can be significantly improved in a reasonable and generally predictable period of time (usually up to six months). Pain management and treatment of long-standing, chronic conditions are specifically listed as Noncovered Services as well as reevaluations, maintenance therapy, patient education, prevention of injuries and conditioning. Services that are not directly related to the patient's specific medical diagnosis, such as conditioning exercise, endurance activities, activities for diversion and activities for general motivation are also listed as Noncovered Services.

3. BCBSM has included in the *Guide* its documentation guidelines for initial and re-evaluations as well as the documentation of individual sessions. The initial evaluation is to include the date of evaluation, a description of the patient's functional level, muscle strength and range of motion, a description of functional level prior to the onset of the current illness or injury, mental status and ability to participate in the treatment program, pain level, type and effect on the treatment program, any circulatory complications and areas of desensitization, a description of skin ulcers, a treatment plan including: the areas of the body to be treated, modalities to be provided, exercises to be provided, frequency of treatments, duration of the procedures, role of supervising staff and patient and family education, rehabilitation potential, treatment goals, anticipated duration of therapy and the signature and credentials of the therapist performing the evaluation.

   BCBSM states documentation must be in the patient record summarizing the patient's response to treatment at least once every two weeks or every five treatment sessions, whichever occurs first. The progress note needs to include the date, the dates of service covered by the progress note, specific and objective evaluation of the patient's progress and response to treatment (changes in range of motion, etc.), changes in medical status, changes in mental status and level of cooperation, changes in the treatment plan with rationale for such changes, and the signature and credentials of the therapist assessing the patient's progress.

   Each treatment session billed must be documented in the patient record. The information to be documented includes the date of service, time of service if treatments are performed more than once per day, duration of service if the billing unit is a time interval, modalities provided at the treatment session, the patient's response to treatment and the signature and credentials of the therapist.

4. BCBSM's initial audit findings letter gives the appearance that services coded as wrong code (WC) and no record of procedure (NRP) were projected to the entire patient

population. BCBSM likely intended to include a projected refund in its letter to Petitioner but inadvertently left such a projection out of the letter. The patient credit refund report associated with the initial audit findings confirms BCBSM failed to include a projection in its audit findings as it totals $152,724.24, the same amount BCBSM requested from Petitioner. The actual services denied for lack of medical necessity total $128,183.32 and the actual services denied for wrong coding, no record of procedure or no order total $24,540.92. The total of all these actual services is $152,724.24.

Note that had BCBSM actually projected these denial codes to the entire patient population the projected portion of the refund would have been thrown out as part of this review and determination process as BCBSM failed to consider the entire patient record for mechanical traction services. Per BCBSM's policy on mechanical traction services, chiropractors may provide mechanical traction services in conjunction with a chiropractic adjustment and bill BCBSM for such services. Because of this payment rule, BCBSM cannot deny the services provided by Petitioner because the services were separately provided by a chiropractor rather than by a physical therapist as part of a physical therapy treatment program. There needn't be a physical therapy order in the patient record when a chiropractor is performing mechanical traction in conjunction with a chiropractic adjustment.

5. Review of the patient record for BCBSM member [redacted] reveals that this patient has had a back chronic condition for over 24 years with no documented functional loss when she presented to Petitioner for treatment. Nothing in the patient record documents the patient had an acute exacerbation of this condition that would require physical therapy treatment. As such, no physical therapy services are approved for this patient. On the other hand, BCBSM's chiropractic benefit allows for chiropractic care, including mechanical traction if a chiropractic adjustment was done on the same date of service. BCBSM policy allows for two chiropractic adjustments per month for patients with chronic conditions. Given BCBSM has acknowledged that flex-distraction is an acceptable form of mechanical traction, two mechanical traction services per month are hereby approved. The approved services total $77.14.

6. The patient record of BCBSM member [redacted] reveals this patient also had a chronic condition. Thus, the patient would be entitled to two chiropractic adjustments per month along with any medically necessary mechanical traction services. Although there is documentation on many dates of service not billed to BCBSM showing the patient had both a chiropractic adjustment and mechanical traction on the same date of service, the patient record does not adequately document that a chiropractor provided the mechanical traction services in conjunction with a chiropractor adjustment on the dates of service actually billed to BCBSM. As such, no services are approved for this patient case.

7. Review of the patient chart for BCBSM member [redacted] reveals BCBSM made inconsistent determinations when reviewing this patient record. This patient had a chronic condition without evidence of a recent exacerbation yet it appears BCBSM inadvertently approved certain services for this patient by recoding them to a different procedure code and only asking for a refund of the difference in payment between the service billed and the recoded service.

   There is little documentation in the patient chart of objective findings that document a functional deficit for this patient. BCBSM coded the mechanical traction services as no record of procedure (NRP) when in fact these services were provided to the patient by a chiropractor rather than the physical therapist. Such coding by BCBSM was inappropriate and unfortunate as such services are typically projected to the entire patient population. However, as noted above, review of BCBSM's audit findings letter reveals that although BCBSM speaks to many services being projected to the patient population, that projection was actually never made. As such, these services cannot now be taken out of a projection that was never made in the first place. As noted in the cases discussed above, BCBSM's chiropractic benefit allows for chiropractic care, including mechanical traction if a chiropractic adjustment was done on the same date of service. Where the patient record demonstrates the mechanical traction services were provided by a chiropractor in conjunction with a chiropractic adjustment, two mechanical traction services per month are hereby approved. These approved mechanical traction services totals $98.08.

8. BCBSM acknowledged at the meeting of the parties that BCBSM member [redacted] had functional deficits necessitating physical therapy treatment. BCBSM approved many services for this patient but denied mechanical traction services as NRP as well as one manual therapy service. Review of the patient record reveals that the mechanical traction services appear to have been provided by a chiropractor in conjunction with a chiropractic adjustment and not in conjunction with the physical therapy services this patient received.

   It is noted in this case that the determinations made in the audit worksheets and the patient credit refund report do not match up exactly with the audit worksheets. The audit worksheets list both approvals and denials for the services billed to BCBSM and the patient credit refund report lists only denials. BCBSM was requested to verify which services it was indeed on record as denying and to provide a current patient credit refund report for this patient. This information was requested on numerous occasions from BCBSM. BCBSM was notified via an e-mail dated January 6, 2011 that if the information was not forthcoming by January 10, 2011, all such services were to be approved for this patient. As no information was received from BCBSM, all services listed on the patient credit refund report are hereby approved, totaling $1,696.42.

9. Review of the patient record for BCBSM member [redacted] reveals that this patient had a shoulder separation from a sledding accident. BCBSM denied the claims for this patient because it found no functional deficits. After review of the patient record, deference is being given to Petitioner for the services, totaling $876.04, provided to this patient through April 6, 2003. The services after April 2, 2003 are not approved inasmuch as the patient record clearly notes that the patient was functioning within normal limits as of April 7, 2003.

10. BCBSM approved many of the services provided to BCBSM member [redacted] because of the patient's inability to sit or stand due to shooting nerve pain. The services that were not approved dealt primarily with mechanical traction services and the lack of a typed version of the physical therapy services provided on October 23, 2002 and October 25, 2002. There is documentation in the patient record for mechanical traction services denied by BCBSM showing the patient had both a chiropractic adjustment and mechanical traction on the same date of service, thus these services are approved.

    It is noted in this case that the determinations made in the audit worksheets and the patient credit refund report do not match up exactly with the audit worksheets. The audit worksheets list both approvals and denials for the services billed to BCBSM and the patient credit refund report lists only denials. BCBSM was requested to verify which services it was indeed on record as denying and to provide a current patient credit refund report for this patient. This information was requested on numerous occasions from BCBSM. BCBSM was notified via an e-mail dated January 6, 2011 that if the information was not forthcoming by January 10 2011, all such services previously denied by BCBSM would be approved for this patient. As no information was received from BCBSM, all services listed on the patient credit refund report are hereby approved totaling $476.76.

11. Inasmuch as only six patient records were actually discussed during the meeting of the parties, it is reasonable to proportionally apply the results of the records reviewed to the audit sample and BCBSM's refund request. Based on the above findings, it is found that BCBSM violated Section 402(1)(f) of the Act by failing to make a good faith attempt at a prompt, fair and equitable settlement on denied claims for BCBSM members [redacted], [redacted], [redacted], [redacted] and [redacted] totaling $3,224.44 that it did not approve prior to the meeting of the parties. This amount represents 26.4% of the total refund requested by BCBSM for the six cases reviewed at the meeting of the parties. Applying this percentage proportionally to BCBSM's refund request, it is found and concluded that BCBSM's refund request of Petitioner is reduced to $102,178.20.

12. If the Petitioner or BCBSM disagree with this decision, a request for a contested case hearing may be submitted within 60 days of the date of this decision. A request for a

contested case hearing should be directed to the Office of Financial and Insurance Regulation's Office of General Counsel.

The Commissioner specifically retains jurisdiction of the matters contained herein together with the authority to issue such order or orders, as he shall deem just, necessary and appropriate.

Date: 2/23/2011

Susan M. Scarane

Susan M. Scarane
Commissioner's Designee